

# Prior Authorization

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[Refer to WAC 388-531-0200]

## What is Prior Authorization (PA)?

The prior authorization (PA) process only applies to covered services and is subject to client eligibility and program limitations. Bariatric surgery is an example of a covered service that requires PA. PA does not guarantee payment.

HRSA's PA requirements are met through the following authorization processes:

- Limitation extensions (LE);
- Written/fax; and
- Expedited prior authorization (EPA).

**Note:** In addition to receiving PA, the client must be on an eligible program. For example, a client on Family Planning Only would not be eligible for bariatric surgery.

## How does HRSA determine PA?

HRSA reviews PA requests in accordance with WAC 388-501-0165. HRSA utilizes evidence-based medicine to evaluate each request. HRSA considers and evaluates all available clinical information and credible evidence relevant to the client's condition. At the time of the request, the provider responsible for the client's diagnosis and/or treatment must submit credible evidence specifically related to the client's condition. Within 15 days of receiving the request from the client's provider, HRSA reviews all evidence submitted and will do one of the following:

- Approve the request;
- Deny the request if the requested service is not medically necessary; or
- Request the provider to submit additional justifying information within 30 days. When the additional information is received, HRSA will approve or deny the request within 5 business days of the receipt of the additional information. If the additional information is not received within 30 days, HRSA will deny the requested service.

When HRSA denies all or part of a request for a covered service or equipment, HRSA sends the client and the provider written notice within 10 business days of the date the information is received that:

- Includes a statement of the action the department intends to take;
- Includes the specific factual basis for the intended action;
- Includes references to the specific WAC provision upon which the denial is based;
- Is in sufficient detail to enable the recipient to learn why the department's action was taken;
- Is in sufficient detail to determine what additional or different information might be provided to challenge the department's determination;
- Includes the client's administrative hearing rights;
- Includes an explanation of the circumstances under which the denied service is continued or reinstated if a hearing is requested; and
- Includes example(s) of lesser cost alternatives that permit the affected party to prepare an appropriate response.

## **Written/Fax Prior Authorization**

### **What is written/fax PA?**

Written/fax PA is an authorization process available to providers when a procedure's EPA criteria have not been met or the covered procedure requires PA. Procedures that require PA are listed in the Fee Schedule (See Appendix). Procedures that are marked with a # sign are noncovered. HRSA does not retrospectively authorize any healthcare services that require PA after they have been provided except when a client has delayed certification of eligibility.

Forms available to request PA include:

Basic Information Form DSHS 13-756  
Bariatric Surgery Request Form [DSHS 13-785]  
Out of State Medical Services Request Form [DSHS 13-787]  
PET Scan Information Form [DSHS 13-757]  
Oral Enteral Nutrition Worksheet Prior Authorization Request [DSHS 13-743]\*

These forms are available at: <http://www1.dshs.wa.gov/msa/forms/eforms.html>

\*See HRSA's Enteral Nutrition Program Billing Instructions for more information.

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Be sure to complete all information requested. Requests that are incomplete will be returned to the provider.

Send one of the completed fax forms listed above to:

HRSA-Division of Medical Management  
Attn: Provider Request/Client Notification Unit  
PO Box 45506  
Olympia, WA 98504-5506  
FAX: (360) 586-1471

## **Limitation Extension (LE)**

### **What is an LE?**

LE is an authorization of services beyond the designated benefit limit allowed in Washington Administration Code (WAC) and HRSA's billing instructions.

**Note:** A request for a limitation extension must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups cover all services.

### **How do I request a LE authorization?**

Some LE authorizations are obtained by using the EPA process. Refer to the EPA section pages I.6-I.11 for criteria. If the EPA process is not applicable, you must request an LE in writing and receive HRSA approval prior to providing the service.

#### **The written request must state all of the following:**

1. The name and PIC number of the client;
2. The provider's name, provider number and fax number;
3. Additional service(s) requested;
4. Copy of last prescription and date of last dispense;
5. The primary diagnosis code and CPT code; and
6. Client-specific clinical justification for additional services.

Complete one of the following forms for LEs:

- Basic Information Form (DSHS 13-756); or
- Physical, Occupational, and Speech Therapy Limitation Extension Request Form [DSHS 13-786]

Send or fax your written request for a limitation extension to:

Division of Medical Management  
HRSA Request Coordinator  
PO Box 45506  
Olympia, WA 98504-5506  
FAX: 360-586-1471

## Expedited Prior Authorization (EPA)

EPA is designed to eliminate the need for written authorization. HRSA establishes authorization criteria and identifies the criteria with specific codes, enabling providers to create an EPA number using those codes.

To bill HRSA for diagnostic conditions, procedures and services that meet the EPA criteria on the following pages, the provider must **create a 9-digit EPA number**. The first six digits of the EPA number must be **870000**. The last 3 digits must be the code assigned to the diagnostic condition, procedure, or service that meets the EPA criteria (see pages I.6-I.11 for codes). Enter the EPA number on the billing form in the *authorization number field*, or in the *Authorization or Comments* section when billing electronically.

**Example:** The 9-digit authorization number for a client with the following criteria would be **870000423**:

- Is 2-years old with prelingual hearing loss; and
- Has a diagnosis of profound sensorineural hearing loss;
- Has stimulable auditory nerves;
- Has cognitive ability to use auditory clues; and
- Willing to undergo an extensive rehabilitation program and is suitable for cochlear implantation with no contraindications for surgery.

**870000** = first six digits of all expedited prior authorization numbers. **423**= last three digits of an EPA number indicating that the above criteria is met.

HRSA denies claims submitted without a required EPA number.

HRSA denies claims submitted without the appropriate diagnosis, procedure code, or service as indicated by the last three digits of the EPA number.

The billing provider must document in the client's file how the EPA criteria were met and make this information available to HRSA on request. If HRSA determines the documentation does not support the criteria being met, the claim will be denied.

**Note:** HRSA requires written/fax PA when there is no option to create an EPA number.

## **Expedited Prior Authorization Guidelines**

### **Documentation**

The provider must verify medical necessity for the EPA number submitted. The client's medical record documentation must support the medical necessity and be available upon HRSA's request. If HRSA determines the documentation does not support the EPA criteria being met, the claim will be denied.

### **Which services require EPA?**

HRSA requires EPA for services noted in WAC, HRSA's billing instructions, and/or fee schedules as needing EPA.

You must complete the Oral Enteral Nutrition Worksheet Expedited Prior Authorization Request [DSHS 13-761] for clients who meet EPA criteria for oral enteral nutrition. The completed form must be kept in the client's chart and a copy sent to the pharmacy or medical vendor supplying the oral enteral nutrition product. This form is available at:

<http://www1.dshs.wa.gov/msa/forms/eforms.html>

If the client does not meet the EPA criteria, the Oral Enteral Nutrition Worksheet Expedited Prior Authorization Request form [DSHS 13-761] must be completed and sent to a pharmacy or medical vendor supplying the oral enteral nutrition product.

**Washington State  
Expedited Prior Authorization Criteria Coding List**

Code	Criteria	Code	Criteria
<b>Blepharoplasties</b>			
<b>CPT:</b> 15822, 15823, and 67901-67908,			
<b>630</b>	Blepharoplasty for noncosmetic reasons when <i>both</i> of the following are true: <ol style="list-style-type: none"> <li>1) The excess upper eyelid skin impairs the vision by blocking the superior visual field;</li> <li>2) On a central visual field test, the vision is blocked to within 10 degrees of central fixation.</li> </ol>		d) The client is willing to undergo an extensive rehabilitation program;  e) There is an accessible cochlear lumen that is structurally suitable for cochlear implantation;  f) Client does not have lesions in the auditory nerve and/or acoustic areas of the central nervous system; and  g) There are no other contraindications to surgery.
<b>Cochlear Implants</b>			
<b>CPT:</b> 69930			
<b>HCPCS:</b> L8615-L8618, L8621-L8624			
<b>Dx.:</b> 389.10-389.18			
<b>423</b>	When <b>one</b> of the following is true: <ol style="list-style-type: none"> <li>1) <b>Unilateral cochlear implantation</b> for adults (age 18 and older) with post-lingual hearing loss and children (age 12 months-17 years) with prelingual hearing loss when all of the following are true:               <ol style="list-style-type: none"> <li>a) The client has a diagnosis of profound to severe bilateral, sensorineural hearing loss;</li> <li>b) The client has stimuable auditory nerves but has limited benefit from appropriately fitted hearing aids (e.g., fail to meet age-appropriate auditory milestones in the best-aided condition for young children, or score of less than ten or equal to 40% correct in the best-aided condition on recorded open-set sentence recognition tests;</li> <li>c) The client has the cognitive ability to use auditory clues;</li> </ol> </li> </ol>	2)	<b>Replacement Parts for Cochlear Implants</b> when all of the following are true: <ol style="list-style-type: none"> <li>a) HRSA has purchased the implant(s);</li> <li>b) The manufacturer's warranty has expired;</li> <li>c) The part is for immediate use, not a back-up part; and</li> <li>d) The part is not an external speech processor (these require written/fax authorization).</li> </ol>

**Note:** Effective for dates of service on and after January 1, 2006, HCPCS code L8619 requires PA.

Code	Criteria	Code	Criteria
<b>Dispensing/Fitting Fees for Glasses</b> CPT: 92340-92342		<b>620 Flexible Frames</b> for adults and children - when the following is documented in the client's record:	
<b>615</b>	<p><b>Glasses (both frames and lenses) – Due to loss or breakage</b> for adults - within 2 years of last dispensing glasses may be replaced when glasses are broken or lost and <b>all</b> of the following are documented in the client's record:</p> <ol style="list-style-type: none"> <li>1) Copy of current prescription (less than 18 months old); <b>and</b></li> <li>2) Date of last dispensing; <b>and</b></li> <li>3) Both frames and lenses are broken or lost.</li> </ol> <p><b>Note:</b> You do not need an EPA # when billing for children or clients with developmental disabilities.</p>	<ol style="list-style-type: none"> <li>1) The client has a diagnosed medical condition that has contributed to two or more broken eyeglass frames in a 12-month period.</li> </ol>	
<b>Dispensing/Fitting Fees for Frames Only</b> CPT: 92340-92342		<b>Dispensing/Fitting Fees for Lenses Only</b> CPT: 92340 - 92342	
<b>618</b>	<p><b>Replacement Frames –Due to loss or breakage:</b> For adults - lost or broken frames may be replaced when <b>all</b> of the following are documented in the client's record:</p> <ol style="list-style-type: none"> <li>1) No longer covered under the manufacturer's 1 year warranty; <b>and</b></li> <li>2) Copy of current prescription demonstrating the medical necessity for prescription eye wear; (see pg. C.3) <b>and</b></li> <li>3) Documentation of broken or lost frames.</li> </ol> <p><b>Note:</b> You do not need an EPA # when billing for children or clients with developmental disabilities.</p>	<b>622</b>	<p><b>Replacement eyeglass lenses - Due to eye surgery/effects of prescribed medication/diseases affecting vision:</b> For adults and children - within 2 years of last dispensing when:</p> <ol style="list-style-type: none"> <li>1) The client has a stable visual condition (see Definition section); <b>and</b></li> <li>2) The client's treatment is stabilized; <b>and</b></li> <li>3) The lens correction must have a 1.0 or greater diopter change between the sphere or cylinder correction in at least one eye; <b>and</b></li> <li>4) The previous and new refraction must be documented in the client record.</li> </ol>
<b>619</b>	<p><b>Durable Frames</b> for adults and children - when the following is documented in the client's record:</p> <ol style="list-style-type: none"> <li>1) The client has a diagnosed medical condition that has contributed to two or more broken eyeglass frames in a 12-month period.</li> </ol>	<b>623</b>	<p><b>Replacement eyeglass lenses – Due to loss or breakage:</b> For adults, lost or broken lenses may be replaced when <b>all</b> of the following are documented in the client's record:</p> <ol style="list-style-type: none"> <li>1) Copy of current prescription (prescription is less than 18 months old); <b>and</b></li> <li>2) Date of last dispensing (if known); <b>and</b></li> <li>3) Documentation of lens damage or loss.</li> </ol> <p><b>Note:</b> You do not need an EPA # when billing for children or clients with developmental disabilities.</p>

Code	Criteria	Code	Criteria
<b>624</b>	<p><b>Replacement eyeglass lenses – Due to headaches/blurred vision/difficulty with school or work:</b> For adults and children - within 2 years of last dispensing, for refractive changes (provider error is the responsibility of the provider to warranty their work and replace the lens at no charge) when <b>all</b> of the following are documented in the client's record:</p> <ol style="list-style-type: none"> <li>1) The client has symptoms e.g., headaches, blurred vision, difficulty with school or work; <b>and</b></li> <li>2) Copy of current prescription (prescription is less than 18 months old for adults); <b>and</b></li> <li>3) Date of last dispensing, if known; <b>and</b></li> <li>4) Absence of a medical condition that is known to cause temporary visual acuity changes (e.g. diabetes, pregnancy); <b>and</b></li> <li>5) A refractive change of at least .75 diopter or greater between the sphere or cylinder correction in at least one eye.</li> </ol>		<ol style="list-style-type: none"> <li>3) The lens correction has a 1.0 or greater diopter change in at least one eye between the sphere or cylinder correction; <b>and</b></li> <li>4) The previous and new refraction are documented in the client record.</li> </ol> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><b>Note:</b> You do not need an EPA # when billing for children or clients with developmental disabilities.</p> </div>
<b>625</b>	<p><b>High index eyeglass lenses</b> for adults and children when <b>one</b> of the following is documented in the client's record:</p> <ol style="list-style-type: none"> <li>1) A spherical refractive correction of +\ - 8.0 diopters or greater; <b>or</b></li> <li>2) A cylinder correction of +\ - 3.0 diopters or greater.</li> </ol>	<b>627</b>	<p><b>Replacement Contact Lenses – Due to loss or breakage:</b> For adults - once every 12 months when contact lenses are lost or damaged <b>and</b> the prescription is less than 18 months old.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><b>Note:</b> You do not need an EPA # when billing for children or clients with developmental disabilities.</p> </div>
<p><b>Dispensing/Fitting Fees for Contacts</b> CPT: 92070, 92310-92317</p>		<p><b>Hyperbaric Oxygen Therapy</b> CPT: 99183</p>	
<b>621</b>	<p><b>Replacement Contact Lenses – Due to eye surgery/effects of prescribed medication/diseases affecting vision:</b> For adults - within 1 year of last dispensing when:</p> <ol style="list-style-type: none"> <li>1) The client has a stable visual condition (see Definition section); <b>and</b></li> <li>2) The client's treatment is stabilized; <b>and</b></li> </ol>	<b>425</b>	<p>When both of the following are true:</p> <ol style="list-style-type: none"> <li>1) The diagnosis is 250.70-250.83; <b>and</b></li> <li>2) Hyperbaric Oxygen Therapy is being done in combination with conventional diabetic wound care.</li> </ol>
		<p><b>Other Reduction Mammoplasties/ Mastectomy for Gynecomastia With Diagnosis of 611.1 Or 611.9</b></p>	
		<b>250</b>	<p>Reduction mammoplasty or mastectomy, not meeting expedited criteria, but medically necessary/medically appropriate in accordance with established criteria. Evidence of medical appropriateness must be clearly evidenced by the information in the client's medical record.</p>

Code	Criteria	Code	Criteria
<b>Meningococcal Vaccine</b> <b>CPT: 90734 (Conjugate Vaccine – Menactra®)</b>		<b>Note:</b> <ol style="list-style-type: none"> <li>1) If the medical condition does not meet one of the above specified criteria, you must obtain prior authorization by submitting a request in writing to QUS (see <i>Important Contacts</i>) or by calling the authorization toll-free number at 800.292.8064.</li> <li>2) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria.</li> </ol>	
<b>421</b>	<p>Client is 11 years of age through 55 years of age and meets in one of the "at risk" groups because the client has one of the following:</p> <ol style="list-style-type: none"> <li>1) Has terminal complement component deficiencies;</li> <li>2) Has anatomic or functional asplenia;</li> <li>3) Is a microbiologist who is routinely exposed to isolates of <i>N. meningitidis</i>; or</li> <li>4) Is a freshman entering college who will live in a dormitory.</li> </ol>		
<b>CPT: 90733 (Polysaccharide vaccine – Menomune®)</b>		<b>HCPCS: L3310 &amp; L3320</b>	
<b>424</b>	<p>Client meets at least 1 of the 5 criteria for use of the meningococcal vaccine outlined for EPA code 421 (CPT code 90734) and <b>one of the following is true:</b></p> <ol style="list-style-type: none"> <li>1) The client is one of the following: <ol style="list-style-type: none"> <li>a) 2 years of age through 10 years of age; or</li> <li>b) Older than 55 years of age.</li> </ol> </li> <li>2) The conjugate vaccine is not available.</li> </ol>	<b>781</b>	<p><b>Lift, elevation, heel &amp; sole, per inch.</b></p> <p>Allowed for as many inches as required (has to be at least one inch), for a client with a leg length discrepancy, on one shoe per 12-month period.</p>
<b>Orthotics</b> <b>HCPCS: L3030</b>		<b>HCPCS: L3334</b>	
<b>780</b>	<p><b>Foot insert, removable, formed to patient foot.</b></p> <p>One (1) pair allowed in a 12-month period if one of the following criteria is met:</p> <ol style="list-style-type: none"> <li>1) Severe arthritis with pain;</li> <li>2) Flat feet or pes planus with pain;</li> <li>3) Valgus or varus deformity with pain;</li> <li>4) Plantar facitis with pain; or</li> <li>5) Pronation.</li> </ol>	<b>782</b>	<p><b>Lift, elevation, heel, per inch</b></p> <p>Allowed for as many inches as required (has to be at least one inch), for a client with a leg length discrepancy, on one shoe per 12-month period.</p>
		<b>Note:</b> <ol style="list-style-type: none"> <li>1) Lifts are not covered for less than one (1) inch.</li> <li>2) Lifts are only allowed on one (1) pair of client shoes.</li> <li>3) If the medical condition does not meet one of the above-specified criteria, you must obtain prior authorization by submitting a request in writing to DMM (see <i>Important Contacts</i>) or by calling the authorization toll-free number at 800.292.8064.</li> <li>4) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria.</li> </ol>	

Code	Criteria	Code	Criteria
<b>HCPCS: L3000</b>			
<b>784</b>	<p><b>Foot insert, removable, molded to patient model, "UCB" type, Berkeley Shell, each</b></p> <p>Purchase of one (1) pair per 12-month period for a client 16 years of age or younger allowed if any of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1) Required to prevent or correct pronation;</li> <li>2) Required to promote proper foot alignment due to pronation; or</li> <li>3) For ankle stability as required due to an existing medical condition such as hypotonia, Cerebral Palsy, etc.</li> </ol>		<ol style="list-style-type: none"> <li>3) To accommodate a partial foot prosthesis; or</li> <li>4) To accommodate clubfoot.</li> </ol>
	<p><b>Note:</b></p> <ol style="list-style-type: none"> <li>1) If the medical condition does not meet one of the above-specified criteria, you must obtain prior authorization by submitting a request in writing to QUS (see <i>Important Contacts</i>) or by calling the authorization toll-free number at 800.292.8064.</li> <li>2) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria.</li> <li>3) If the client only medically requires one orthotic, right or left, prior authorization must be obtained.</li> </ol>		<p><b>Note:</b></p> <p>HRSA does not allow orthopedic footwear for the following reasons:</p> <ol style="list-style-type: none"> <li>1) To accommodate L3030 orthotics;</li> <li>2) Bunions;</li> <li>3) Hammer toes;</li> <li>4) Size difference (mismatched shoes); or</li> <li>5) Abnormal sized foot.</li> </ol>
			<p><b>Reduction Mammoplasties/ Mastectomy for Gynecomastia</b></p> <p><b>CPT:</b> 19318, 19140 <b>DX:</b> 611.1 and 611.9 only</p>
		<b>241</b>	<p>Diagnosis for <i><b>hypertrophy of the breast</b></i> with:</p> <ol style="list-style-type: none"> <li>1) Photographs in client's chart, <i>and</i></li> <li>2) Documented medical necessity including: <ol style="list-style-type: none"> <li>a) Back, neck, and/or shoulder pain for a minimum of one year, directly attributable to macromastia, <i>and</i></li> <li>b) Conservative treatment not effective; <i>and</i></li> </ol> </li> <li>3) Abnormally large breasts in relation to body size with shoulder grooves, <i>and</i></li> <li>4) Within 20% of ideal body weight, <i>and</i></li> <li>5) Verification of minimum removal of 500 grams of tissue from each breast.</li> </ol>
		<b>242</b>	<p>Diagnosis for <u><b>gynecomastia</b></u>:</p> <ol style="list-style-type: none"> <li>1) Pictures in clients' chart, <i>and</i></li> <li>2) Persistent tenderness and pain, <i>and</i></li> <li>3) If history of drug or alcohol abuse, must have abstained from drug or alcohol use for no less than one year.</li> </ol>
<b>HCPCS: L3215 or L3219</b>			
<b>785</b>	<p><b>Orthopedic footwear, woman's or man's shoes, oxford.</b></p> <p>Purchase of one (1) pair per 12-month period allowed if any of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1) When one or both shoes are attached to a brace;</li> <li>2) When one or both shoes are required to accommodate a brace with the exception of L3030 foot inserts;</li> </ol>		

Code	Criteria	Code	Criteria
<b>Strabismus Surgery</b> <b>CPT: 67311-67340</b>			
<b>631</b>	<p>Strabismus surgery for clients 18 years of age and older when <i>both</i> of the following are true:</p> <ol style="list-style-type: none"> <li>1) The client has double vision; and</li> <li>2) It is not done for cosmetic reasons.</li> </ol>		
<b>Visual Exam/Refraction</b> <b>(Optometrists/Ophthalmologists only)</b> <b>CPT: 92014-92015</b>			
<b>610</b>	<p><b>Eye Exam/Refraction - Due to loss or breakage:</b> For adults within 2 years of last exam when no medical indication exists and <b>both</b> of the following are documented in the client's record:</p> <ol style="list-style-type: none"> <li>1) Glasses that are broken or lost or contacts that are lost or damaged; <b>and</b></li> <li>2) Last exam was at least 18 months ago.</li> </ol> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><b>Note:</b> You do not need an EPA # when billing for children or clients with developmental disabilities.</p> </div>		

## HRSA-Approved Centers of Excellence (COE)

[Refer to WAC 388-531-0650, WAC 388-531-0700, and WAC 388-531-1600]

The following services must be performed in an HRSA-approved Center of Excellence (COE) and **do not require prior authorization**. See the next page for a list of COEs.

- Organ/bone marrow/peripheral stem cell transplants;

**Note:** As required by federal law, organ transplants and services related to an organ transplant procedure are not covered under the AEM program.

- Inpatient Chronic Pain Management; or
- Sleep studies (CPT codes 95805, 95807-95811).

**Note:** When billing on a paper HCFA-1500 claim form, note the COE in field 32. When billing electronically, note the COE in the *Comments* section.

Bariatric Surgery must be performed in an HRSA-approved COE and **requires PA**.

## HRSA-Approved Organ Transplant Centers of Excellence (COE)

[\*Refer to WAC 388-531-1750 and WAC 388-550-2000]

APPROVED TRANSPLANT HOSPITALS	ORGAN(S)	CPT CODE
<b>Children's Hospital &amp; Medical Center/Seattle</b>	<ul style="list-style-type: none"> <li>Bone Marrow (BMT) (autologous &amp; allogenic)</li> <li>Peripheral Stem Cell Transplant (PSC-T)</li> <li>Heart</li> <li>Liver</li> <li>Kidney</li> <li>Small Bowel</li> </ul>	<ul style="list-style-type: none"> <li>38230, 38240-38242</li> <li>38205-38206, 38240-38242</li> <li>33945</li> <li>47135-47136, 47143-47147</li> <li>50360, 50365, 50380</li> <li>44132, 44133, 44137, 44715, 44720, 44721</li> </ul>
<b>Dorenbacher Children's Hospital/Portland NW Marrow Transplant Program (PSC-T only)</b>	<ul style="list-style-type: none"> <li>BMT</li> <li>PSC-T</li> </ul>	<ul style="list-style-type: none"> <li>38230, 38240-38242</li> <li>38205-38206, 38240-38242</li> </ul>
<b>Fred Hutchinson Cancer Research Center/Seattle</b>	<ul style="list-style-type: none"> <li>BMT</li> <li>PSC-T</li> </ul>	<ul style="list-style-type: none"> <li>38230, 38240-38242</li> <li>38205-38206, 38240-38242</li> </ul>
<b>Good Samaritan Hospital Medical/Puyallup</b>	<ul style="list-style-type: none"> <li>PSC-T</li> </ul>	<ul style="list-style-type: none"> <li>38205-38206, 38240-38242</li> </ul>
<b>Inland NW Blood Center</b>	<ul style="list-style-type: none"> <li>PSC-T</li> </ul>	<ul style="list-style-type: none"> <li>38205-38206, 38240-38242</li> </ul>
<b>Legacy Good Samaritan Hospital/Portland (Northwest Marrow Transplant Program)</b>	<ul style="list-style-type: none"> <li>BMT</li> <li>PSC-T</li> </ul>	<ul style="list-style-type: none"> <li>38230, 38240-38242</li> <li>38205-38206, 38240-38242</li> </ul>
<b>Mary Bridge Children's Hospital/Seattle</b>	<ul style="list-style-type: none"> <li>PSC-T (autologous only)</li> </ul>	<ul style="list-style-type: none"> <li>38206, 38242</li> </ul>
<b>Oregon Health Sciences University (OHSU)/Portland</b>	<ul style="list-style-type: none"> <li>Heart</li> <li>Liver</li> <li>Kidney</li> <li>Pancreas</li> </ul>	<ul style="list-style-type: none"> <li>33945</li> <li>47135-47136</li> <li>50360, 50365, 50380</li> <li>48160, 48554</li> </ul>
<b>Providence St. Peter Hospital/Olympia</b>	<ul style="list-style-type: none"> <li>PSC-T</li> </ul>	<ul style="list-style-type: none"> <li>38206, 38240-38242</li> </ul>
<b>Sacred Heart Medical Center/Spokane</b>	<ul style="list-style-type: none"> <li>Kidney</li> <li>Heart</li> <li>Heart/Lung(s)</li> <li>Lung</li> </ul>	<ul style="list-style-type: none"> <li>50360, 50365, 50380</li> <li>33945</li> <li>33935</li> <li>32851-32854</li> </ul>
<b>Seattle Cancer Care Alliance/Seattle</b>	<ul style="list-style-type: none"> <li>BMT</li> <li>PSC-T</li> </ul>	<ul style="list-style-type: none"> <li>38230, 38240-38242</li> <li>38205-38206, 38240-38242</li> </ul>
<b>St. Joseph's Hospital/Tacoma</b>	<ul style="list-style-type: none"> <li>BMT (autologous only)</li> <li>PSC-T</li> </ul>	<ul style="list-style-type: none"> <li>38230, 38242</li> <li>38205-38206, 38240-38242</li> </ul>

## HRSA-Approved Organ Transplant Centers of Excellence (COE) (Cont.)

[\*Refer to WAC 388-531-1750 and WAC 388-550-2000]

APPROVED TRANSPLANT HOSPITALS	ORGAN(S)	CPT CODE
Swedish Medical Center/Seattle	<ul style="list-style-type: none"> <li>• Kidney</li> <li>• PSC-T</li> </ul>	<ul style="list-style-type: none"> <li>• 50360, 50365, 50380</li> <li>• 38231, 38240-38241</li> </ul>
University of Washington Medical Center/Seattle	<ul style="list-style-type: none"> <li>• BMT</li> <li>• PSC-T</li> <li>• Heart</li> <li>• Heart/Lung(s)</li> <li>• Lung</li> <li>• Kidney</li> <li>• Liver</li> <li>• Pancreas</li> </ul>	<ul style="list-style-type: none"> <li>• 38230, 38240-38241</li> <li>• 38231, 38240-38241</li> <li>• 33945</li> <li>• 33935</li> <li>• 32851-32854</li> <li>• 50360, 50365, 50380</li> <li>• 47135-47136</li> <li>• 48160, 48554</li> </ul>
Virginia Mason Hospital/Seattle	<ul style="list-style-type: none"> <li>• Kidney</li> <li>• Pancreas</li> <li>• BMT</li> <li>• PSC-T</li> </ul>	<ul style="list-style-type: none"> <li>• 50360, 50365, 50380</li> <li>• 48160, 48554</li> <li>• 38230, 38240-38241</li> <li>• 38231, 38240-38241</li> </ul>

***HRSA-Approved Sleep Study Centers*****[Refer to WAC 388-531-1500]**

<b>HRSA Approved Sleep Centers</b>	<b>Location</b>
ARMC Sleep Apnea Laboratory	Auburn Regional Medical Center - Auburn, WA
Center for Sleep Medicine	Mid Columbia Medical Center - Dalles, OR
Eastside Sleep Disorders Center	Overlake Hospital Medical Center - Bellevue, WA
Harrison Medical Center Sleep Disorders Center	Harrison Medical Center - Bremerton, WA
Highline Sleep Disorders Center	Highline Medical Center - Burien, WA
Holy Family Sleep Center	Holy Family Hospital -Spokane, WA
Kathryn S. Dement Sleep Disorders Center	St. Mary's Medical Center - Walla Walla, WA
KGH Columbia Sleep Lab	Kennewick, WA.
Multicare Sleep Disorders Center	Tacoma General Hospital/ or Mary Bridge Children's Hospital and Health Center- Tacoma, WA
North Olympic Sleep Center	Silverdale, WA
Olympic Medical Center—Sleep Center	Olympic Medical Center Port Angeles, WA
Providence Sleep Health Institute	Providence Everett Medical Center - Everett, WA.
Richland Sleep Disorders Center	Richland, WA
Sleep Center at Valley Medical Center	Valley Medical Center Renton, WA
Sleep Center for Southwest Washington	Providence St. Peter - Olympia, WA
Sleep Center of Central Washington	Yakima Memorial Hospital – Yakima, WA
Sleep Disorder Clinic Legacy Good Samaritan Hospital and Medical Center	Legacy Good Samaritan Hospital and Medical Center - Portland, OR
Sleep Disorders Center Virginia Mason Medical Center	Virginia Mason Medical Center - Seattle, WA
Sleep Disorders Program Center	Children's Hospital and Regional Medical Center- Bellevue, WA

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## Physician-Related Services

HRSA Approved Sleep Centers	Location
St. Clare Sleep Related Breathing Disorders Laboratory	St. Clare Hospital - Tacoma, WA
St. Frances Sleep Disorder Center	St. Frances Hospital – Federal Way, WA
St. Joseph Regional Medical Center Sleep Lab	St. Joseph Regional Medical Center - Lewiston, ID
Swedish Sleep Medicine Institute	Providence Swedish or Swedish First Hill - Seattle, WA
The Sleep Institute of Spokane	Sacred Heart Medical Center or 104 W. 5 <sup>th</sup> Suite 400 W - Spokane, WA
UW Medicine Sleep Disorders Center at Harborview	Harborview Medical Center - Seattle, WA
Vancouver Sleep Disorders Center	Vancouver Neurology - Vancouver, WA

### Providers must:

- Use CPT codes 95805 and 95807-95811 for sleep study services.
- Enter the approved HRSA sleep center's provider number where the sleep study/polysomnogram or multiple sleep latency testing was performed. (Refer to previous page for appropriate location of HRSA-approved sleep center.) Enter the provider number in either box 19 or 32 on the HCFA-1500 claim form. When billing electronically, note the provider number in the *Comments* section.
- Obtain an ENT consult for children younger than 10 years of age prior to study.
- Sleep studies are limited to rule out obstructive sleep apnea or narcolepsy.

**Note:** The following is a list of approved diagnoses for sleep studies: **327.10, 327.11, 327.12, 327.14, 327.20, 327.21, 327.23, 327.26, 327.27, 327.42, 327.51, 347.00-347.11, 780.51, 780.53, 780.54, and 780.57**

## *HRSA-Approved Inpatient Pain Clinics*

HRSA-Approved Inpatient Pain Clinic
St. Joseph Hospital & Health Care Center, Tacoma

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## ***HRSA-Approved Bariatric Hospitals and Their Associated Clinics***

<b>HRSA Approved Bariatric Hospital and Associated Clinics</b>	<b>Location</b>
University of Washington Medical Center, University of Washington Specialty Surgery Center	Seattle, WA
Oregon Health Science University, OHSU Surgery Center	Portland, OR
Sacred Heart Medical Center, Rockwood Bariatric Specialists	Spokane, WA

## ***HRSA-Approved Hospitals for Bariatric Surgery***

HRSA covers medically necessary bariatric surgery in an approved hospital with a bariatric surgery program in accordance with WAC 388-531-1600. Prior authorization is required. To begin the authorization process, providers should fax HRSA a completed “Bariatric Surgery Request form [DSHS # 13-785] to:

HRSA – Division of Medical Management  
 Attn: Provider Request/Client Notification Unit  
 PO Box 45506  
 Olympia, WA 98504-5506  
 FAX: 360.586.1471

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